



Church Street United Methodist Church  
900 Henley Street ~ Knoxville, TN ~37902  
865-521-0293 ~ Fax 865-521-0288

## **Medical Assessment Form**

Participant's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

1. Date of most recent exam:

2. List participant's diagnosis:

3. List current medications:

4. Any known drug allergies:

5. Is there a history of psychiatric illness, alcohol, or chemical dependency?



6. Is there a therapeutic diet or dietary restrictions? Please indicate.
  
7. List any special needs or assistance required by the participant.  
(assistance eating, help in the bathroom, etc.)
  
8. List any physical limitations, restrictions, or gait problems.
  
9. Does the participant have any communicable disease? Has there been a chest x-ray in the last 6 months? What was the result?
  
10. In your medical opinion, is there any reason the participant should not participate in the Kay Senior Care Center program?

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_